The following is a comprehensive list of issues and recommendations that were brought up by providers and reviewed by the Department of Behavioral Health, Department of Health Care Policy And Financing, and Public Consulting Group. The issues have been divided into two groups; those from the March 2010 Trainings, and, those developed by the A&A Review Committee. In this document, DBH, HCPF, and PCG provide responses and clarifications to each of the issues raised. Please note that some items remain open and will be re-reviewed during the course of the coming year. Additionally, there is a hotline available to all providers to use while completing the cost report. The hotline number is: 1-800-251-9498.

IMPORTANT: The FY2010 Cost Reports may be used in the rate setting process. This first year of reporting will be done on a preliminary basis, to allow: a) centers time to get their systems in place, b) DBH and HCPF time to see how centers response to the Cost Reports so that further efficiencies can be made. While there is no formal audit required of the FY2010 Cost Reports, it is expected that Supplementary Cost Report will be completed to the best quality possible and submitted with Annual Audited Financial Statements.

PART 1. Training Feedback Questions – Supplementary Cost Report

SUMMARY SCHEDULE 1:

1) **Update guidelines:** Centers asked for clarification of what an unduplicated client count really is. What about clients who switched payers throughout the year or have two payers?

RESPONSE: Compute average cost per client calculation for the center from schedule 5, additionally, and calculate average cost per payer. If the client switches payers throughout the year, the client will be recorded in multiple lines. If the client has two payers, please record the client according to the primary payer in the provider's billing system.

2) **Update template:** Centers and auditors expressed concern regarding which part of the report will be audited.

RESPONSE: FY 2010 will not be audited. The state will work with Centers and auditors following year one in determining how this report will be audited.

SCHEDULE 2:

1) **Update guidelines**: Questions were raised regarding where should RNs and APNs go. What about other Mid-level providers like PAs, nurses, nurse practitioners?

RESPONSE: Classify providers based on education level. The State and providers can work on this in further revisions.

2) **Update guidelines**: Questions regarding modifiers on schedule 2. Centers don't think they are collecting those HIPPA modifiers.

RESPONSE: HIPPA modifiers should be on submitted bills.

3) **Update guidelines/Center Question**: Which HCPC codes should be included in emergency and lab services? Centers asked that code ranges be included in each column to provide further guidance.

RESPONSE: Centers should use 4 and 4A as a reference tool. If there is no RVU for that lab or emergency service, then it should be included in Column 9. If it has an RVU, then it should go in Column 3. This methodology should be applied to all column headings.

4) **Update template**: Column 4 heading--specify that this column is "inpatient hospital" not just "inpatient" to minimize confusion over terminology.

RESPONSE: Agreed

5) **Update template and guidelines:** Make 2 substance abuse columns: one for substance abuse RVUs and substance abuse with no RVUs.

RESPONSE: Agreed

6) **Update template and guidelines:** Where should Centers put client costs and client transportation? Also include row for "Transportation for clients?"

RESPONSE: Input these costs in the Client Costs line. This line has been added above the indirect costs section on the cost report.

7) **Update guidelines:** Major concerns were raised regarding bundling or un-bundling services. Currently, most centers are bundling/unbundling based on payer source, not program. Centers expressed desire for more clarification regarding which practice is preferred now and in the future. They express concern that inconsistent bundling/un-bundling will drastically affect Centers' base unit rate. How should they account for no-shows/programs where staff is required to be there regardless of clients?

RESPONSE: Centers are encouraged to unbundle and identify discrete services that have specific RVU weights (i.e., the service is located on schedules 4/4A). The State recognized that for residential services the cost report are asking centers to unbundle on Schedule 1, but bundle on Schedule B. In Year 2 of this cost report, the State will provide guidance re: what they expect Centers to bundle/unbundle, as there will likely be inconsistencies.

8) **Update template:** Unallowable costs do not need to be allocated across columns.

RESPONSE: The Cost Report template has been changed so that centers can enter unallowable costs in only column 2.

9) How do we capture the non-client costs associated with any CPT Code, such as travel time related to therapy, or food costs associated with services.

RESPONSE: Non-client costs that are specific to a service should be reported in the "other expenses" line 15.

10) Will there be more clarification on lines 1 and 17 of Schedule 2 regarding which administrative staff should be included in each line?

RESPONSE: Line 1- Direct Administrative Staff, should include all positions that can be assigned to a specific program associated with columns 3-11 (i.e., program directors, program managers, and other administrative positions). Consistent with the A&A Guidelines, Line 17-Administration and General, Column 2, is an indirect cost line that should encompass all costs (including operational and staff salaries) that cannot be directly associated with a specific program. These center-wide administrative costs will be allocated across programs on Schedule 3. Any administrative and general costs (both operational and staff salaries) that can be assigned to a program in columns 3-11 should be reported in the appropriate column.

SCHEDULE 3and 3a

1) **Update template:** Are all the rows necessary? Only one or two really apply to centers.

RESPONSE: This is not an urgent issue. The State will review FY10 cost reports to determine whether or not it wants to eliminate columns in future cost reports.

2) **Update guidelines**: Clarify interest expense—should it be allocated as an overhead allocation at end or directly go to building—suggestion that interest expense should be an overhead allocation for all.

RESPONSE: Please follow the A& A Guidelines.

3) **Update template**: Update allocation methods from square feet to something more appropriate (particularly for medical records).

RESPONSE: Agreed. Centers may use the allocation statistic that it currently uses to allocate costs. In year two the State may want to require specific statistics to be used, but will leave it up to the provider in year one.

4) **Update template and guidelines**: Centers asked how they should allocate between direct service areas and indirect service areas on 3a because right now the statistics are just stepped down to indirect. Auditor suggested that ideally calculations would be based on square footage to calculate direct costs similar to Medicare cost report.

   RESPONSE: Follow A& A Guidelines

SCHEDULE 4 and 4a

11) **Update guidelines:** Centers wondering if line 53 includes Residential and ATU.

   RESPONSE: If the center is discretely identifying the service, then yes, it goes in line 53.

12) **Update guidelines:** Centers requested further clarification regarding dual-eligible clients and different scenarios. Centers expressed major concern over how this would be done. They want to see methodology State comes up with and work to refine it.

   RESPONSE: ***CHANGE***: The providers should be able to use their billing system in order to identify the payer. A&A guidelines have been adjusted.

13) **Update guidelines:** Question raised that if client loses Medicaid eligibility during year and then gets back on, where center should put them on the schedule. Should they be considered indigent?

   RESPONSE: See question 12 response.

14) **Update template**: Centers suggested creating 2 columns (internal capitation and "external BHO Medicaid").

   RESPONSE: Agreed, columns have been added to report.

15) Major concerns were raised regarding the distinction between facility and non-facility. The centers' concerns are that many services with a "facility" POS are actually off-site for them and should be considered "non-facility" or "off-site," as Non-Facility RVUs provide more funding. State open to creating new guidelines regarding this issue.

   RESPONSE: Language in the A & A Guidelines has been updated to reflect recommended change:

   > On-site refers to provider sites that are discrete primary locations owned or leased by a provider for purposes of providing behavioral health services; off-Site refers to all other locations. However, the purposes of RVU assignment, residential sites owned or leased by a provider are considered off-site.

16) How is the primary Payer to be determined? Is there a hierarchy of Payers?

RESPONSE: The payer listed first on service bill is considered the primary payer.

SCHEDULE A

1) Many centers questioned relevance of schedule A as it involves a separate allocation methodology. Centers suggested that no one has a system set up like this now so the allocation is going to be different for each center. Such arbitrary allocations would also result in no solid audit trail. Many asked "Why keep at all?"

   RESPONSE: Schedule A has been modified to become a statistical cost calculation for DBH funded programs. This schedule will now be completed in the same manner as Schedules 4, 4A, and 5. Units must be entered according to DBH-funded program and facility or non-facility place of service. The total DBH cost calculation should tie to the DBH cost on Schedule 5.

SCHEDULE B and C

1) Centers expressed frustration that rows on Schedule B didn't match previous schedules (particularly schedule 2) and other expense reports they have to run. Many asked why this schedule breaks out expenses in yet another way.

2) Many questions regarding how to deal with bundling or unbundling on Schedule B. Centers suggested ideally deleting schedule B. Some concerns raised regarding capacity issues such as when therapists have to be in ATU at all times. Many argued that per diem/bundled cost would allow for easier comparison between facilities. Others emphasized importance of tying schedule B to schedule 2 which would involve

RESPONSE: Former Schedule B has been eliminated. To Schedule C (now Schedule B), the following changes have been made:

1) Add total costs column
2) Add Supportive Housing into the column heading

Part 2. A&A Review Committee Recommendations
The following is a summary of responses to the Review Committee's recommendations to the A&A guidelines.

Page 2-8 Depreciation
Issue: Disallowance of portion of cost of buildings and equipment. What constitutes costs borne by state or federal government is unclear.

RESPONSE: Language will be kept as-is in the A&A Guidelines. The language will be reviewed for year two.

Page 2-9 Loss on Other Awards
Issue: This is applicable only to specific contracts and not in relation to overall cost allowability.

RESPONSE: Language will be kept as-is for year one. Removing this language would put the State in a position of micromanaging each center's separate grants and contracts.

Page 2-9 Memberships.
Issue: It is felt that this is far too detailed a transaction for DBH / HCPF to have to approve.

RESPONSE: The guidelines have been updated to reflect the new language:
"Costs of membership in any country club or social or dining club are unallowable. "

Page 2-9. Organization Costs
Issue: These start-up costs are a part of doing business and should be allowable.

RESPONSE: State will keep language in A&A guidelines and provide a protocol document to notify DBH of changes/expansion.

Page 2-9. Parent Company/Management Costs
Issue: Center Review Committee recommended striking the following paragraph from the guidelines:

> Parent Company/Management Costs/Related Party Transactions will not be allowed unless they are actual costs. These costs need to be supported by a company-wide cost allocation plan, which must be submitted as an appendix to the BHO or CMHC annual financial statement. For instance, the cost of a regional manager who supervises multiple facilities will be that regional manager's salary appropriately allocated to the respective facilities that are supervised.

RESPONSE: This language will be kept in the A&A Guidelines because it is a specific related party transaction issue that should have controls on it.

Page 2-9 Travel Expenses

Issues: Simplification and ease of setting travel expense limits. The IRS rate is more readily available.

RESPONSE: The State has modified the language in the A&A Guidelines as the following:

> **Travel Expenses.** Travel expenses for only official functions are allowed; reimbursement for such expenses may not exceed the most economical and reasonable costs. Reimbursement may not exceed actual costs or per diem for staff members; likewise, cost for official travel may not exceed the limits set by the Internal Revenue Service.

Page 3-12. Financial Reporting Guidelines

Issue: The contract does not require agreed upon procedures testing anymore nor do auditors currently audit the unit cost schedules. It is also not consistent with Page 3-11 "Statistical System".

RESPONSE: The State agrees to the recommended changes to reflect the following language:

Financial Reporting Guidelines

The annual audits of financial statements and the attestation report with respect to the statistical system are the primary documents used to monitor the unit cost reimbursement system and the encounter systems. The audits provide credibility to the reimbursement system and the encounter systems presented to the Legislature. Thus, DBH and HCPF require that the auditor specifically express an attestation opinion on the supplementary information.

Authoritative pronouncements of the accounting profession dictate the form and substance of reports on the audit of supplementary data. Required financial statements are presented as Exhibits A and B, however if changes are made to the Healthcare Audit Guide conforming changes must be made to the financial statement presentation. The Supplemental Cost Report, which is used in part to calculate the Provider's base unit cost, is included in Exhibit C. The required auditor's attestation opinion is to be addressed to these figures.

Management Letter

The auditor is required to communicate to the board of directors any material weaknesses or significant deficiencies in accordance with the Statement on Auditing Standards 115. In addition, oftentimes auditors communicate other control matters referred to as management letters.

DBH / HCPF requires copies of SAS 115 communication and management letter along with a copy of the response by the CMHC or BHO management to its Board.

1. The evaluation of the issues commented on by the auditor;

2. Proposed courses of action to remedy the weakness or to modify the system or structure as suggested specifying both action steps and a timetable.

Care should be exercised by the auditor to ensure that management letter comments which represent findings to be reported under the requirements of OMB Circular A-133 are appropriately included in the applicable report.

Page 3-13. Related Party Transactions
Issue: The primary concern here is that there is not a definition of which entities are considered related. Since the BHO's members / partners are the CMHS's, the sub-capitation paid to the CMHS might mistakenly be considered a related party transaction in the strictest sense of the definition.

RESPONSE: The State did not adopt the suggested addition of highlighting that "sub-capitation payments are not considered related party transactions". Sub-capitation payments for services is not within context – sub-capitation payments are revenue to a center, and this report captures expenses.

Page 4-11. Schedule 4 – Utilization (Encounter-Based Mental Health Services With Non-Facility RVU Weights), and
Page 4-13. Schedule 4a – Utilization (Encounter-Based Services With Facility RVU Weights)
Issue: The definition of Non-Facility and Facility was to have been inserted in these sections, but was not included. Further, Non-Facility and Facility Place of Service are defined on Page 6 of the "Relative Value Unit (RVU) Schedule" manual, but the tables accompanying it, on pages 7 & 8 of that manual are contradictory to the definition.

RESPONSE: The State has inserted the following recommended language into the A&A Guidelines for clarity:

> For clarity, the terms "on-site" and "off-site" may offer less complex descriptions in the day-to-day clinical practice of community mental health center (CMHC) and clinic staff. On-site refers to provider sites that are discrete primary locations owned or leased by a provider for purposes of providing behavioral health services; off-Site refers to all other locations. However, for the purposes of RVU assignment, residential sites owned or leased by a provider are considered off-site.

Chapter 6 –Mental Health Revenues In Excess Of Mental Health Costs
Issue: There are a number of concerns noted:

- This does not contain the 7% allowable amount calculated over a rolling 5 years.

- How is this relevant if we are "earning" the contract dollars through valuing the encounters for Indigent clients through the data side?

- Should costs include all costs related to treating DBH qualified clients – up to the contract amount and then all qualified clients exceeding the contract? We continue to treat even though we have met the contract number requirements.

- Two different ways to value the same contract is an administrative burden and could result in disparate information.

RESPONSE: The State agreed with the recommendation of striking this section.

Reporting Requirements

Issue: Will providers be required to submit Annual Financial Statements (exhibit A in the guidelines)?

RESPONSE: Yes, providers and BHOs will use the A&A Guidelines for the completion of Annual Financial Statements. They will also be required to submit the supplementary Cost Report.